PAS Eligibility Criteria

Technical Assistance for the Medicaid Infrastructure Grants

Centers for Medicare & Medicaid Services

Medicaid Infrastructure Grants issued by CMS were created by the Ticket to Work and Work Incentives Improvement Act of 1999. This Act requires states that receive grant funding to make personal assistance services (PAS) available under the Medicaid State Plan to the extent necessary to enable individuals with disabilities to remain employed. The Act defines "employed" as earning at least minimum wage and working at least 40 hours per month. The Act defines PAS as a range of services designed to assist an individual in performing daily activities on and off the job.

Given the parameters that were established by the law, CMS designed a tiered eligibility structure for the Medicaid Infrastructure Grant that enables many states to qualify for funding while making incremental improvements to the state's Medicaid personal assistance services. As is detailed below, key elements of a state's PAS delivery system include whether the system delivers services of at least 40 hours per month, whether the services can be offered at the worksite if necessary, and if the services are limited to only a small part of the population through provision on a less than statewide basis or by offering services only through limited waivers.

In summary: *Conditionally eligible* States are those which offer personal assistance services inside and outside the home through their Medicaid programs in a statewide manner sufficient in amount, duration and scope to support an individual who is working 40 hours per month. Beginning in 2002, a State may apply as a conditionally eligible State if it commits to these criteria by the end of the first grant year. *Fully eligible States* must meet all of the requirements of conditionally eligible States but must offer PAS services sufficient to support an individual in full-time competitive employment. States may meet both Conditional and Full eligibility levels through State plan services, waivers or a combination of both. Fully eligible and conditionally eligible States are able to apply for and receive multi-year grant awards. Conditionally eligible States must meet annual benchmarks representing improvements to the State's PAS program to receive future funding. States with full or conditional eligibility will receive funding at the beginning of the grant cycle. Other States may not currently qualify to receive funding under the grant but may wish to apply in order to have some of the grant funding reserved for them for up to two years, permitting the State time to make improvements to personal assistance services.

States that formerly qualified as "transitionally eligible" may submit applications for either full or conditional eligibility as applicable. The "Transitional Eligibility" category was removed because the differences between transitional and conditional eligibility were

often too fine to distinguish in a uniform and equitable manner. States that received funding under the "transitional" category will receive three additional years of funding at the conditional level if qualified.

Eligibility for the Medicaid Infrastructure Grant largely depends of the ability of the Medicaid program in any state to provide adequate personal assistance services to support a person in competitive employment; and at the highest levels, to support a person in full-time competitive employment. Eligibility for this grant, however, should not be confused with Medicaid program rules. Overarching principles of comparability and amount, duration and scope cannot be violated to qualify for this time-limited grant program. Changes to PAS delivery systems must maintain the integrity of the Medicaid program and its rules without regard to the grant program.

What's New?: There are two new elements to the PAS classification system. Beginning with the new applications in the third grant cycle (due in 2002), CMS developed an eligibility scoring tool. Secondly, for new applications in the fourth grant cycle (due in 2003), CMS has added the requirement that fully eligible States include a letter from the State Medicaid Director attesting to three elements of the states' PAS system as described below.

Scoring Tool

In order to further objectify the criteria used by CMS to determine eligibility, the charts on the following pages were developed and will be in use beginning in the 2003 grant cycle. They will be used by CMS staff to determine the eligibility for all new applications as well as for all States currently participating in the MIG program as the States reapply competitively for funding (in most cases, after the first 4 years of funding.) The actual ranking of States will be performed in the CMS Central Office with input from the Regional Office contacts and the States. However, for reference, the actual instruments that will be used follow. The ranking tools are designed to be used as flow charts with a series of subsequent decisions made from the top of the charts to the bottom. The ranking tools begin with an evaluation of the State Plan Service and move on to an evaluation of waivers as applicable.

A. State Plan Tool

In using the State Plan Tool, CMS staff will examine the level of service offered to employed adults with disabilities through the optional Medicaid service even though the service will not be limited to only the employed. For example, if a State offers an enhanced benefit to the competitively employed, CMS will use the enhanced level of service in its evaluation. Services offered under EPSDT to those under 21 will not be considered. Lastly, CMS will evaluate the services that are offered to the categorically

needy. If a State has a medically needy program and does not offer the service to the medically needy, the State will not be penalized for purposes of this grant program.

The scoring tool itself looks at the *location* where services are available, the *maximum number of hours* that a person can receive services, and the *population served* by the service.

Location: All States will be divided into one of three groups. The first group is those that offer PAS in any location deemed necessary to meet individual need. In other words, a person can receive services inside and outside the home including at the workplace if necessary. The second group includes States that offer PAS inside and outside the home but not at the worksite. States would fall under this category if they offered PAS in the home and PAS to assist an individual to public transportation or to the grocery store but not at a job. The third category is inside the home only, or inside and outside only to get to non-employment related activities. For example, this category would include States that offer PAS inside the home and outside the home only as necessary to get an individual to medical appointments.

Maximum Hours: The second consideration relates to the question of whether the State imposes a maximum number of hours of PAS that an individual may receive. States may determine the number of hours a service may be provided within broad parameters from CMS that the amount of the service must be sufficient to meet the purpose of the service. Again States will be classified in one of three categories including: 40 hours a week or more; between 39.9 hours a week and 40 hours a month; or less than 40 hours a month.

Population Served: Like the other categories, this again places States in one of three groups labeled "all", "some", or "minimal". The basic measure for this categorization is whether the service is open to "all" who might need it, or restricted to "some" who might need it or limited to a "minimal" subgroup of those who might need it to be competitively employed. Specifics are attached to the chart.

Once determinations are made for each of these three factors, the eligibility is determined according to the chart. However, unless a State is determined fully eligible based solely on the State plan service, the State's waivers must be evaluated before assessing final eligibility. If a State has 1915(c), 1915(b) waivers, or 1115 demonstrations that serve both individuals with mental retardation and/or developmental disabilities (MR/DD) *and* individuals with physical disabilities (PD), the State's waivers must be evaluated to determine the final eligibility category.

B. Waiver Tool

The waiver scoring tool is similar in that it is designed to be used as a flow chart. The elements on the waiver tool are *statewide*, *location*, *sufficiency*, and whether the waiver is *open to individuals from the Medicaid buy-in* categorical eligibility group if a State has one.

States may qualify for a Medicaid Infrastructure Grant eligibility criteria based solely on waivers or States may increase their eligibility score from a State plan service based on waivers, but in order to do so the State must have waivers that serve both the MR/DD and physically disabled populations. If a State has multiple waivers for a particular target group with different design features, scoring will be done with the waiver that is the most relevant.

Statewide: Self-explanatory.

Location: For purposes of waivers, inside and outside the home means that PAS services are offered wherever needed including at the worksite. Inside and outside the home limited means PAS services are offered inside the home and outside the home but not at the worksite.

Sufficiency: Category A under sufficiency means that the number of individuals served by the waiver is equal to or greater than 75% of the number of individuals estimated to qualify for the waiver in that State. The population estimate is derived from the Home and Community-Based Services State-by-State Population Tool, a project of the Lewin consulting group.

Open to Individuals from the Medicaid Buy-In: The last element reflects the property of waivers whereby a State chooses to open or restrict a waiver to particular eligibility groups. Since the Medicaid buy-in is a categorically needy eligibility group, States must open its waivers to members of this group in order for working individuals with disabilities to benefit from PAS offered under a waiver. As an element of the scoring tool, this is simply a yes/no category.

To reach the eligibility level for waivers, a State receives the lower of the two scores between the MR/DD waiver and the PD waiver (remembering that a State must have both.)

C. Scoring Tool

A State's final eligibility for a Medicaid Infrastructure Grant is determined using the State Plan and Waiver Scoring Sheet. As shown on the sheet, if a State has a fully eligible State plan, waivers are not considered and the State is determined fully eligible. If a State does not have PAS in its Medicaid plan or if a State has a State plan service that meets the categorical or reserved level, then waivers are evaluated and the State can be raised to the level of the waivers, if higher than the State plan service. To reach Conditional or Full eligibility based on waivers, a State must reach the Conditional or Full eligibility level on both major waivers, not one or the other. Waivers will not be used to downgrade the eligibility level that a State receives based on its State plan service.

Attestation Letter

States that apply for the Full eligibility category through the fourth round of the Medicaid Infrastructure Grant (due in 2003) or later must submit a letter from the State Medicaid Director as part of the grant application attesting to the following mandatory elements of the State's personal assistance services delivery system.

Mandatory elements of Fully eligible systems:

- A State must have criteria for reviewing and responding to requests from qualified employed individuals with disabilities who believe they require more services than determined at their individual assessment, or a different type of physical or cognitive assistance than that which has been made available. Such criteria should be developed in consultation with individuals with disabilities who use personal assistance services and are competitively employed; and

- Workers receiving personal assistance services must be able to receive personal assistance services at times during both the day and night seven days a week, subject to a finding of individual need; and

- Unless an individual needs only assistance with activities of daily living, medical necessity definitions used by a State must not preclude the availability of personal assistance services for instrumental activities of daily living such as cooking, cleaning or shopping if such assistance is required for an individual to remain competitively employed.

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